STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155793	A. BUILDING 00 B. WING	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON TRACE OF FISHERS LLC	11851 CUMBERLAND RD FISHERS, IN 46037

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F0000	This survey was for a Recertification and State Licensure Survey. Survey dates: January 7, 8, 9, 10, 11, 14, 15 & 16, 2013. Facility number: 012644 Provider number: 155793 AIM number: 201046710 Survey team: Christi Davidson, RN-TC Janet Stanton, RN Michelle Hosteter, RN Census bed type: SNF: 36 SNF/NF: 64 Residential: 32 Total: 132 Census payor type: Medicare: 33 Medicaid: 36 Other: 63 Total: 132 Residential sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	February 8, 2013 Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on January 16, 2013. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace's credible allegation of compliance. We allege compliance on February 15, 2013. We are requesting a desk review for this plan of correction. I If you have any further questions, please do not hesitate to contact me at (317) 813-4444. Sincerely, Melissa Hampton, HFA Administrator Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality Review completed on January 25, 2013, by Brenda Meredith, R.N.		Recertification and State Licensure Survey on January 16, 2013. Please accept this plan of correction as Hamilton Trace of Fisher's credible allegation of compliance by February 15, 2013. This statement of deficiencies and plan of correction will be reviewed at the April Quality Assurance/Assessment Committee meeting.	

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F0156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on observation, record review and interview, the facility failed to prominently display, in an area readily accessible and frequented by most residents, written information related to Resident Rights, names/addresses/phone numbers of all pertinent State advocacy groups, and written information about applying and use of Medicare and Medicaid benefits. This deficiency had the potential to affect 100 of 100 residents residing in the certified nursing facility area. Findings include: The initial observation tour was conducted on 1/7/13, beginning at 10:05 A.M., on the 300-400 Wing, 600-700 Wing, 800 Wing, and 500/Alzheimer's secured locked unit.	F0156	**F156 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The State advocacy groups addresses and phone numbers were posted in the main lobby. Residents #134, #37 and family member of resident #47 were notified of the location of the Resident Rights posting, State advocacy groups posting, and information about applying and use of Medicare and Medicaid benefits displayed in the community. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident's residing in the facility had the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not**	02/15/2013

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	Signs related to Resident Rights, State advocacy groups, or Medicare/Medicaid application and use, were not located on any of the units. ON 1/7/13 at 11: 30 A.M., an observation was done in the front lobby at the main facility entrance. No Resident Rights or Medicare/Medicaid information, and no advocacy phone numbers were found. On 1/7/13 at 1:26 P.M., the front lobby was observed again. An 8 by 10 inch sheet of paper with the State advocacy addresses and phone numbers was observed in a clear plastic document holder, placed at the rear of a small table just inside the main doors to the lobby. A paper titled "Resident Rights for Housing with Services Establishment" was located in a frame, and hanging on the wall in a short hallway between the front lobby and a cross-hallway to the nursing units. The paper addressed "housing rights" rather than Resident Rights as required and listed in the Federal regulation. During the daily conference on 1/11/13 at 4:45 P.M., the Administrator and Consultant Nurse		**recur.** A copy of the required information of the following has been posted: resident rights, names, addresses and telephone numbers of all pertinent State client advocacy groups, the Medicaid Fraud control unit, and a statement regarding how to apply for and use Medicare and Medicaid benefits, and how to receive funds. Residents and families will be educated upon admission where this information can be located. In addition, each unit has a posting detailing the location of these documents within the facility. **IV The facility will monitor the corrective action by implementing the following measures.** The postings will be reviewed monthly for 6 months to ensure compliance. Location of resident rights, state advocacy groups and applying and use of Medicare and Medicaid will be reviewed in resident council monthly 3 months then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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	indicated the agency phone numbers were in the plastic holder on the table, and had thought the paper posted for "Resident Rights" was the correct one. In an interview on 1/14/13 at 11:19 A.M., Resident #134 indicated she had not seen any signs for agencies, resident rights, or Medicare. She indicated she once had a booklet on Resident Rights, but does not have it anymore. She did not know where any of the above information could be found posted in the facility. She indicated she was able to get around the facility using her wheelchair, but did not go to the front lobby. In an interview on 1/14/13 at 11:27 A.M., Resident #37 indicated she had not seen and did not know where any of the above information could be found posted in the facility. She indicated she was able to get around the facility using her wheelchair, but did not go to the front lobby. In an interview on 1/14/13 at 11:34 A.M., a family member for Resident #47 indicated she had gotten a booklet on Resident Rights, but had not seen any signs posted on that or the other information, and did not know where it might be located.			

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	3.1-4(a) 3.1-4(j)(3) 3.1-4(l)			

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F0167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to prominently display and post a notice of their availability in an area frequented by most residents, the results of the most recent survey conducted by Federal or State surveyors, and any plan of correction. This deficiency had the potential to affect 100 of 100 residents residing in the certified nursing facility area. Findings include: The initial observation tour was conducted on 1/7/13, beginning at 10:05 A.M., on the 300-400 Wing, 600-700 Wing, 800 Wing, and 500/Alzheimer's secured locked unit. Signs related to the location of the survey results were not located on any of the units. On 1/7/13 at 11: 30 A.M., an	F0167	**F167** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The survey results binder was displayed in the front lobby beside the main entrance in the community. Residents #134, #37 and family member of resident #47 were notified of the location of the survey results. **II. The facility will identify**	02/15/2013

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	observation was done in the front lobby at the main facility entrance. No survey results or sign on location was found. On 1/7/13 at 1:26 P.M., the front lobby was observed again. A survey book/binder was located on front table at front of building next to main entrance door. The title was facing away from the main traffic pattern. During the daily conference on 1/11/13 at 4:45 P.M., the Administrator and Consultant Nurse indicated the survey book was located on the table in the front lobby and was easily accessible to all residents. In an interview on 1/14/13 at 11:19 A.M., Resident #134 indicated she did not know where the survey book could be found, and had not seen any signs posted in the facility on its location. She indicated she was able to get around the facility using her wheelchair, but did not go to the front lobby. In an interview on 1/14/13 at 11:27 A.M., Resident #37 indicated she did not know where the survey book was, but was sure she could ask someone and they would tell where it was. She indicated she was able to get around		**other residents that may potentially be affected by the deficient practice.** Resident's residing in the facility had the potential to be affected. **III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** All new admissions and their families will be educated upon admission on how to locate the survey results. In addition, each unit has a posting detailing the location of the survey results within the facility. **IV The facility will monitor the corrective action by implementing the following**	

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	the facility using her wheelchair, but did not go to the front lobby. In an interview on 1/14/13 at 11:34 A.M., a family member for Resident #47 indicated she had not seen the survey book and had not seen any signs posted on its location. 3.1-3(b)(1)		**measures.** The posting will be reviewed monthly for 6 months to ensure compliance. Location of survey results binder will be reviewed in resident council monthly 3 months then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop Care Plans addressing range of motion services and activity programming for 1 resident who had contractures and stayed in bed (Resident #81); and addressing dialysis access site services for 1 resident who had a hemodialysis shunt access site (Resident #74); in a sample of 29 residents reviewed for Care Plans. Findings include:	F0279	**F279 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The care plans for resident #81 have been updated to reflect appropriate interventions. The care plan for resident #74 has been updated to reflect appropriate interventions. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Current residents with contractures or receiving dialysis could potentially be affected. Care Plans for residents with contractures or	02/15/2013

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	1. The clinical record for Resident #81 was reviewed on 1/15/13 at 9:50 A.M. Diagnoses included, but were not limited to, Stage 4 Pressure Ulcer, paraplegia, muscle weakness, cognitive impairment, colostomy, joint contractures, anemia, narcolepsy, diabetes, neurogenic bladder, chronic kidney disease, osteoporosis, depressive disorder, atrial fibrillation, and chronic leukemia in remission. A. In an interview on 1/9/13 at 10:35 A.M., L.P.N. #3 indicated the resident had bilateral leg contractures, and was not currently receiving any therapy, restorative care, or routine range of motion exercises. She was unsure if he had any splints or devices, and indicated she would call a family member. Later, L.P.N. #3 reported the family member indicated the resident had splints at home, and would bring them in to have the Physical Therapy department evaluate them and the resident for needs. An Admission MDS [Minimum Data Set] assessment, dated 7/25/12, indicated the resident had a BIMS [Brief Interview for Mental Status] score of "12" [8-12=moderately impaired]; and lower extremity impairment of both sides.		receiving dialysis were reviewed and updated as needed to determine that appropriate interventions were present. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Staff were re-educated on the development of comprehensive care plans. Facility will have an outside provider review Activity care plans of residents with contractures quarterly for one year to ensure compliance. Nurses have been provided education on the requirement to update the care plan for any residents who develop contractures, begin dialysis and/or when the intervention in place needs to be changed for more appropriate care and treatment of a resident. **IV The facility will monitor the corrective action by implementing the following measures.** The DON/designee will review care plans of residents with contractures and/or residents receiving dialysis monthly for 3 months and then quarterly thereafter for a total of 12 months. Facility will have an outside provider review Activity care plans of residents with contractures quarterly for one year to ensure compliance. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of	

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	A Quarterly MDS, dated 10/20/12, indicated the resident was independent regarding tasks of daily care--he was able to make consistent and reasonable decisions; and had bilateral impairment of the lower extremities. A 7/10/12, "Admission Nursing Assessment" indicated the resident had no functional ROM [range of motion] impairment of the upper extremities; had impairment of the bilateral lower extremities with paralysis from the chest down, and no contractures. A 8/31/12, acute care hospital Physical Therapy Progress and Discharge Summary indicated "Exhibits bilateral lower extremity flexed position in bed. Tolerates bilateral lower extremity stretching in all planes." A Care Plan addressing the contractures was not found. On 1/7/13, the attending physician gave an order for "P.T. [Physical Therapy] to evaluate and treat for contracture management." On 1/8/13, Physical Therapy wrote an order for "P.T. evaluation completed		reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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	this date. To be seen 5 times/week, for 2 weeks for contracture management. In an interview on 1/15/13 at 11:58 A.M., the Physical Therapy Department Manager indicated she had spoken with his therapist, who saw resident in July, 2012, after his admission, until 8/31/12. She and the resident's therapist did not know anything about a splint from that time. She indicated when she went the end of last week to look, the splint was in the closet. The resident told her the splint was from another facility and never fit; he would not wear it. The P.T. Manager indicated Nursing staff usually provided routine ROM exercises when needed. She indicated she had no other information at that time, but would look for any Care Plan or other documentation regarding splints or PROM [passive range of motion] provided. At that time, she provided an electronic health record report, titled "PT--Therapist Progress & Discharge Summary," dated 8/31/12. The report indicated the resident the resident received "skilled training and education on therapeutic exercises and wheelchair mobility which allowed transition of care from therapy to the patient and caregiver." The residents			

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	155793	A. BUILDING 00 B. WING	01/16/2013

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	"current" level of function for "Positioning" was "The patient exhibits bilateral lower extremity flexed position in bed. Patient tolerates bilateral lower extremity stretching in all planes." There was no documentation related to use of splints or provision of ROM exercises. In an interview on 1/16/13 at 10:00 A.M., Resident #81 indicated the Nursing staff had not been doing any kind of exercises on his legs until the end of last week. He said "It really feels good." B. In an interview on 1/9/13 at 10:16 A.M., Resident #81 indicated he had not been involved with any of the facility activities due to the pressure sore on his bottom, but had plenty to do in his room at this point in time. He indicated he had been "pretty much staying in bed," but the sore was almost healed so he would be getting up more. He indicated he will explore available activities as he becomes more mobile and up for longer periods of time. One Activity Department progress note, dated 7/13/12, indicated "As resident begins to acclimate to transition to new facility, Act. staff will invite and encourage to attend			

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	activities of interest." There were no other Activity progress notes found. The Admission M.D.S., dated 7/25/12, indicated it was "Important" to the resident to choose his bedtime, have family involved with care decisions, use phone in private, and have his belongings locked up. It was "Somewhat important" for him to have books/magazines/newspapers, to listen to music, to be around animals/pets, to keep up with news, to do his favorite activity, and to get outside to get fresh air. On 1/15/13 at 11:58 A.M., the Activity Director provided copies of the electronic health record entries for "Activity Assessment" with dates of 9/17/12 and 10/31/12. The assessment forms listed the residents personal history [demographics]; resident interview on the level of importance of his preferences, and his current interests. The assessments indicated the resident liked board games [kind not listed], cooking, current events, dining out, movies [type not listed], outdoor games [kind not listed], and music/radio [kind not listed]. The "Focus of [Activity] Programming" was listed as "Independent Activities; Intellectually Stimulating Activities;			

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	Rehab-Oriented Activities; Relaxation Activities; Religious Activities; Social Interaction Activities; Talk-Oriented Activities." One Care Plan entry, dated 8/12/12, addressed "Health status has not remained stable and has widely affected capacity for participation in activities. The "Approaches" were listed as: "Rely on coordinated communication with nursing to establish optimal combination of activity settings." There was no other Care Plan entry found addressing activity programming for this resident. 3. In an interview on 1/11/13 at 9:40 A.M., L.P.N. #2 stated "Resident [#74] has a shunt in her right arm. We have to check the bruit/thrill. She used to have a perma-cath, but it clotted off or something." The clinical record for Resident #74 was reviewed on 1/14/13 AT 1:12 P.M. Diagnoses included, but were not limited to, end-stage renal disease, dysphagia, shortness of breath, depressive disorder, chronic total occlusion coronary artery with cath, chronic pain, and diabetes.			

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	An Admission M.D.S. [Minimum Data Set], dated 8/17/12, indicated the resident had a BIMS [Brief Interview for Mental Status] score of 15 [13-15=cognitively intact], and receiving dialysis. A Quarterly M.D.S., dated 11/4/12, indicated the same. One Care Plan, dated 8/10/12, addressed an issue of "Resident has dialysis related to renal failure." The "Approaches" were listed as "Notify MD of any concerns; Administer medication as ordered; Assess for fluid excess, diet as ordered, monitor and record intake of food and fluids; monitor intake and output; monitor weight daily, notify M.D. and family of significant weight change." There was no Care Plan addressing care of the dialysis access site, checking for patency of the shunt, emergency procedures in case of bleeding from the site, or not using the arm with the shunt for blood pressures or blood test draws. During the daily conference on 1/11/13 at 4:45 P.M., the Administrator and Director of Nurses were given the opportunity to submit documentation of a Care Plan addressing the care of the dialysis			

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	access site and emergency plans. At the final exit on 1/16/13 at 4:30 P.M., no additional Care Plan entries or documentation were provided for review. 3.1-35(b)(1)			

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F0318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to ensure 1 of 1 residents reviewed who had contractures did not have a further decrease in his range of motion [ROM]. [Resident #81] Findings include: In an interview on 1/9/13 at 10:13 A.M., Resident #81 indicated he was not able to voluntarily move his legs, and that neither of his legs could be extended out straight. He was observed at that time to have both legs bent at the knees, and he was sitting with them flexed in a crossed "Indian" style manner. In an interview on 1/9/13 at 10:35 A.M., L.P.N. #3 indicated the resident had bilateral leg contractures, and was not currently receiving any therapy, restorative care, or routine range of motion exercises. She was	F0318	**F318** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident #81 was re-evaluated by therapy and is receiving proper range of motion services based on the assessment. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	02/15/2013

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	unsure if he had any splints or devices, and indicated she would call a family member. Later, L.P.N. #3 reported the family member indicated the resident had splints at home, and would bring them in to have the Physical Therapy department evaluate them and the resident for needs. The clinical record for Resident #81 was reviewed on 1/15/13 at 9:50 A.M. Diagnoses included, but were not limited to, Stage 4 Pressure Ulcer, paraplegia, muscle weakness, cognitive impairment, colostomy, joint contractures, anemia, narcolepsy, diabetes, neurogenic bladder, chronic kidney disease, osteoporosis, depressive disorder, atrial fibrillation, and chronic leukemia in remission. An Admission MDS [Minimum Data Set] assessment, dated 7/25/12, indicated the resident had a BIMS [Brief Interview for Mental Status] score of "12" [8-12=moderately impaired]; and lower extremity impairment of both sides. A Quarterly MDS, dated 10/20/12, indicated the resident was independent regarding tasks of daily care--he was able to make consistent and reasonable decisions; and had		Residents who have contractures could be affected. Residents with contractures were assessed for proper treatment and updated as needed. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Residents will be screened for range of motion on a quarterly basis and as needed. If a resident has shown a decline in range of motion an appropriate program will be established. Therapy has been re-educated on how to transition residents who have been discharged from treatment. Therapist will train nursing associates on therapeutic exercises prior to discharge from treatment.	

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	bilateral impairment of the lower extremities. A 7/10/12, "Admission Nursing Assessment" indicated the resident had no functional ROM [range of motion] impairment of the upper extremities; had impairment of the bilateral lower extremities with paralysis from the chest down, and no contractures. A 8/31/12, acute care hospital Physical Therapy Progress and Discharge Summary indicated "Exhibits bilateral lower extremity flexed position in bed. Tolerates bilateral lower extremity stretching in all planes." A Care Plan addressing the contractures was not found. On 1/7/13, the attending physician gave an order for "P.T. [Physical Therapy] to evaluate and treat for contracture management." On 1/8/13, Physical Therapy wrote an order for "P.T. evaluation completed this date. To be seen 5 times/week, for 2 weeks for contracture management. In an interview on 1/15/13 at 11:58 A.M., the Physical Therapy		**IV The facility will monitor the corrective action by implementing the following measures.** Therapy Director or designee will audit the residents with contractures therapy screens monthly for 3 months then quarterly thereafter for a total of 12 months. DON or designee will audit discharge summaries, of residents who remain in the facility with contractures, for transition of care and initiation of programs related to range of motion exercises monthly for 3 months then quarterly thereafter for a total of 12 months. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be	

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	Department Manager indicated she had spoken with his therapist, who saw resident in July, 2012, after his admission, until 8/31/12. She and the resident's therapist did not know anything about a splint from that time. She indicated when she went the end of last week to look, the splint was in the closet. The resident told her the splint was from another facility and never fit; he would not wear it. The P.T. Manager indicated Nursing staff usually provided routine ROM exercises when needed. She indicated she had no other information at that time, but would look for any Care Plan or other documentation regarding splints or PROM [passive range of motion] provided. At that time, she provided an electronic health record report, titled "PT--Therapist Progress & Discharge Summary," dated 8/31/12. The report indicated the resident the resident received "skilled training and education on therapeutic exercises and wheelchair mobility which allowed transition of care from therapy to the patient and caregiver." The residents "current" level of function for "Positioning" was "The patient exhibits bilateral lower extremity flexed position in bed. Patient tolerates bilateral lower extremity stretching in all planes." There was		adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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	no documentation related to use of splints or provision of ROM exercises. In an interview on 1/16/13 at 10:00 A.M., Resident #81 indicated the Nursing staff had not been doing any kind of exercises on his legs until the end of last week. He said "It really feels good." 3.1-42(a)(2)			

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F0332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free of a medication rate of five percent or greater. During medication pass observation, 3 medication pass errors were made in 58 opportunities, for 1 of 14 residents observed, resulting in an error rate of 5.17241 %. [Resident #205; R.N. #5] Findings include: On 1/10/13 at 9:00 A.M., nine medications were listed in the e-MAR [electronic Medication Administration Record] to be given to Resident #205 at the morning medication pass. R.N. #5 was observed to dispense one tablet of each of prescribed medications. According to the prescription labels on the medication boxes, two tablets each of Diltazem, Vitamin D, and Vitamin B-12 were to be dispensed. The resident should have received 12 pills. When questioned, R.N. #5 indicated	F0332	**F332** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** No residents were adversely affected. RN #5 received 1:1 education regarding correct procedure for medication administration with medication administration observation to determine compliance. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents receiving oral medications could be affected.	02/15/2013

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	she had 9 pills in the cup to be administered. The nurse then reviewed the e-MAR, and indicated she just realized she should have dispensed two tablets each of the Diltazem, Vitamin D, and Vitamin B-12. The nurse then dispensed an additional tablet for the Diltazem, Vitamin D, and Vitamin B-12 before administering it to the resident. 3.1-25(b)(9)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Licensed nursing staff have been re-educated on appropriate medication administration techniques. **IV The facility will monitor the corrective action by implementing the following measures.** Staff Development Coordinator or designee will audit by observation of medication administration rotating shifts 3 times per week for 4 weeks, then weekly for one month, then monthly for a total of 12 months. Any identified concerns from the audits will be addressed	

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			immediately. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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F0334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on record review and interview the facility failed to obtain annual consents for influenza and pneumococcal vaccinations, and the facility failed to document in the resident's medical record that information regarding the risks and benefits of receiving the pneumococcal and influenza vaccinations was provided for 4 of 5 residents reviewed for the pneumococcal and influenza vaccination program. (Resident #72, #110, #127, #124) Findings include:	F0334	**F334** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Residents, #110 and #124 responsible parties were notified, and consent or declination was received after	02/15/2013

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	1. The record for Resident #72 was reviewed on 1/14/13 at 2:10 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, hypertension, depressive disorder, diabetes and generalized anxiety disorder. An Electronic Medication Record [EMAR] for Resident #72 indicated the influenza virus vaccine was administered on 10/9/12. A progress note, dated 10/9/12 at 1:26 p.m., for Resident #72 indicated, "Resident received (sic) Flu [influenza] Vaccination today. Tolerated well, no adverse reactins (sic) noted. Will continue to monitor." The record for Resident #72 lacked documentation of a consent for the influenza vaccination, and the record lacked documentation that education regarding the risks and benefits of the vaccination was provided prior to administering the influenza vaccine. 2. The record for Resident #110 was reviewed on 1/14/13 at 2:16 p.m. Diagnoses included, but were not limited to, congestive heart failure,		education was provided regarding the influenza and pneumococcal immunization vaccinations. Letter to all responsible parties educating them on the risks and benefits of the Influenza and Pneumococcal immunization vaccines was sent in September 2012. Follow up phone calls occurred for any resident/responsible party that refused the vaccinations in October 2012. Letter has been scanned in to residents #72, #110, #127, and #124 medical records. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident medical records were audited for declination in the previous calendar year to determine residents who had the potential to be affected. Residents not receiving the	

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	155793	A. BUILDING 00 B. WING	01/16/2013

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	dementia, osteoarthrosis, hypertension, diabetes and anemia. The record for Resident #110 lacked documentation of a declination for the pneumococcal and influenza vaccination, and the record lacked documentation that education regarding the risks and benefits of the pneumococcal and influenza vaccination was provided annually. 3. The record for Resident #127 was reviewed on 1/14/13 at 2:22 p.m. Diagnoses included, but were not limited to, cerebrovascular disease, hypertension, dementia with behavioral disturbance, depressive disorder and osteoporosis. An EMAR for Resident #127 indicated the influenza virus vaccine was administered on 10/27/12. A progress note, dated 10/27/12 at 3:38 p.m., for Resident #127 indicated, "...flu [influenza] vaccine given in lt. [left] deltoid. Tolerated well." The record for Resident #127 lacked documentation of a consent for the influenza vaccination, and the record lacked documentation that education		vaccinations responsible parties were notified, and consent or declination was received after education was provided regarding the influenza vaccination. Education was documented in the resident's medical record. Letter to all responsible parties educating them on the risks and benefits of the Influenza and Pneumococcal immunization vaccines was sent in September 2012, and has been scanned in to resident's medical records. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Facility will provide annual influenza and pneumococcal immunization vaccine education to each resident/responsible party annually. A copy of the education provided will be documented in the resident's	

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	regarding the risks and benefits of the vaccination was provided prior to administering the influenza vaccine. 4. The record for Resident #124 was reviewed on 1/14/13 at 2:40 p.m. Diagnoses included, but were not limited to cerebrovascular disease, depressive disorder, dementia with delusions, and hypertension. The record for Resident #124 lacked documentation of a declination for the pneumococcal and influenza vaccination, and the record lacked documentation that education regarding the risks and benefits of the pneumococcal and influenza vaccination was provided annually. During an interview on 1/14/13 at 2:33 p.m., the DoN indicated the resident or the resident's responsible party signed a consent or declination for the pneumococcal and influenza vaccinations upon admission. The DoN indicated the consent contained a statement that indicated the resident and/or responsible party would not have to resign the form for the remainder of the resident's stay, but could notify facility staff if they wanted to change the decision. The DoN indicated education regarding		medical record. Resident/responsible party sign consent upon admission stating that they have been educated on the risks and benefits of the Influenza and Pneumococcal immunization vaccines and accept or deny the vaccine. The form will be placed in the resident's medical record upon receipt. RN/LPN will provide annual flu/pneumonia vaccine education prior to giving immunizations. Residents refusing vaccines in the past will be given education and given the opportunity to accept or refuse the immunization on an annual basis. Education will be documented in the resident's medical record. **IV The facility will monitor the corrective action by implementing the following measures.**	

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	the risks and benefits of the pneumococcal and influenza vaccinations was sent annually to keep residents informed; however, the DoN could not provide documentation of the education on the resident's medical record for Residents #72, #110, #127 or #124. The facility policy provided by the DoN on 1/7/13 at 11:18 a.m. indicated, "...The resident or legal representative will be provided information and education regarding the benefits and potential side effects of the influenza vaccinations on an annual basis...Provision of such education shall be documented in the resident's medical record...A consent form will be signed to designate informed consent or refusal of the influenza vaccine...they will not have to re-sign this form for succeeding years...but must notify the facility of this decision change. Unless otherwise notified, the facility will administer the vaccine on an annual basis. If the resident and/or responsible party refuses the administration of the vaccine, they will continue to receive the information and education regarding the benefits and potential side effects annually. Continued refusal will be documented in the medical record...."		HIM Director or designee will track consents monthly and report findings to DON. Any consent not received will receive a follow up call to re-educate and determine vaccination status. Results of the reviews will be presented at the monthly Quality Assurance Committee meetings and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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	3.1-13(a)			

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F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview the facility failed to prominently display, in an area readily accessible and frequented by most residents, written data related to daily nursing staffing. This deficiency had the	F0356	**F356 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The required nurse staffing information was posted during the survey beside the main	02/15/2013

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	potential to affect 100 of 100 residents residing in the certified nursing facility area. Findings include: The initial observation tour was conducted on 1/7/13, beginning at 10:05 A.M., on the 300-400 Wing, 600-700 Wing, 800 Wing, and 500/Alzheimer's secured locked unit. Posted information related to daily nursing staffing was not located on any of the units. On 1/7/13 at 11: 30 A.M. an observation was done in the front lobby at the main facility entrance. An 8 by 10 inch piece of paper, listing the current day's nursing staffing, was placed in a small clear plastic holder, which was placed on table in the lobby next to the main entrance. The plastic holder was turned slightly, so that it was facing away from main entrance doorway and traffic pattern. During the daily conference on 1/11/13 at 4:45 P.M., the Administrator and Consultant Nurse indicated the nursing staffing data was posted in the plastic holder on the table in the front lobby, and was accessible by all residents. They indicated the facility did not post this		entrance in the main lobby of the community. Residents #134, #37 and family member of resident #47 were notified of the location of the nurse staffing information. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident's residing in the facility had the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** All new admissions and their families will be educated upon admission on how to locate the staffing posting. In addition, each unit has a posting detailing the location of the nurse staffing information within the facility. **IV The facility will monitor the corrective action by implementing the following measures.** The posting will be reviewed monthly for 6 months to ensure compliance. Location of nurse staffing information will be reviewed in resident council monthly 3 months then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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	information on each unit in order to make the areas more home-like. In an interview on 1/14/13 at 11:19 A.M., Resident #134 indicated she had not seen any posted information related to daily nursing staffing, but would certainly like to know where it was. She indicated she was able to get around the facility using her wheelchair, but did not go to the front lobby. In an interview on 1/14/13 at 11:27 A.M., Resident #37 indicated she had not seen any posted notice related to daily nursing staffing. She indicated she was able to get around the facility using her wheelchair, but did not go to the front lobby. In an interview on 1/14/13 at 11:34 A.M., a family member for Resident #47 indicated she had had seen the staffing notice on front table in the front lobby, but had only noticed it one day when she was leaving. The resident indicated he had not seen the notice, and did not know where it was. 3.1-13(a)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure food was served in a sanitary manner for residents. This practice had the potential to affect 96 of 100 residents who eat food served from the kitchen. Findings include: In an observation on 1/7/13 at 12:20 P.M. Dietary Aid # 1 after touching scoops, steamtable separators, hot pads, and paper towel holder placed her bare fingers in pureed bread and broccoli when putting the steampan with food in it back into the wells. She was serving residents in the skilled nursing dining area at the time. In an interview with the Administrator, on 1/16/13 at 9:15 A.M., she indicated this should not happen when residents are being served their food. A policy regarding handling of food while serving residents in dining areas	F0371	**F371 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** No residents were identified as having been affected. Dining Services employee was re-educated on proper food handling techniques. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents who receive pureed meals in the Skilled Dining room could be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Current Dining Service employees were re-educated on proper food handling techniques. **IV The facility will monitor the corrective action by implementing the following measures.** Dining Services employees in the skilled dining room will be monitored 3 times a week for 4 weeks, weekly times 4 weeks, monthly times 1 month then quarterly thereafter for a	02/15/2013

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	was requested on 1/8/13 at 4:15 P.M. The policy that was provided was on glove use which did not apply due to Dietary Aid #1 not having gloves on at the time. 3.1-21(i)(3)		total of 12 months for food service compliance. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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R0000	The following Residential findings were cited in accordance with 410 IAC 16.2-5.	R0000	February 8, 2013 Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on January 16, 2013. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace's credible allegation of compliance. We allege compliance on February 15, 2013. We are requesting a desk review for this plan of correction. I If you have any further questions, please do not hesitate to contact me at (317) 813-4444. Sincerely, Melissa Hampton, HFA Administrator Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual	

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			Recertification and State Licensure Survey on January 16, 2013. Please accept this plan of correction as Hamilton Trace of Fisher's credible allegation of compliance by February 15, 2013. This statement of deficiencies and plan of correction will be reviewed at the April Quality Assurance/Assessment Committee meeting.	

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R0026	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation and interview, the facility failed to prominently display, in an area readily accessible and frequented by most residents, written information related to Resident Rights. This deficiency had the potential to affect 32 of 32 residents residing in the licensed Residential/Assisted Living area of the facility. Findings include: During the environmental tour on 1/16/13 at 8:50 A.M., with LPN #6 in	R0026	**R0026 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident #205 (should be #505) was notified of the location of the Resident Rights posting. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident's residing in the facility had the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not**	02/15/2013

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	attendance, a copy of the Resident Rights information was not found to be posted in the licensed Residential/Assisted Living area of the facility. In an interview at that time, LPN #6 indicated there was a posted with Resident Rights, and pointed to a framed sign on the wall in the center lounge area by the Nurse's Station. The sign was titled "Resident Rights for Housing with Services Establishments" and addressed housing rights, rather than Resident Rights as required and listed in the State Licensure rules. The nurse indicated she thought that was the correct information, and it was the only sign currently posted. In an interview on 1/16/13 at 10:00 A.M., Resident #205 indicated she had not seen any signs related to Resident Rights.		**recur.** A copy of the required information for Resident Rights has been posted. **IV The facility will monitor the corrective action by implementing the following measures.** The posting will be reviewed monthly for 6 months to ensure compliance. Location of the Resident Rights will be reviewed in resident council monthly for 3 months then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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R0033	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to prominently display, in an area readily accessible and frequented by most residents, written information related to the names/addresses/phone numbers of all pertinent State advocacy groups. This deficiency had the potential to affect 32 of 32 residents residing in the licensed Residential/Assisted Living area of the facility. Findings include: During the environmental tour on	R0033	**R0033 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident #205 (should be #505) was notified of the location of the State advocacy groups posting. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident's residing in the facility had the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does**	02/15/2013

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	1/16/13 at 8:50 A.M., with LPN #6 in attendance, a copy of the State advocacy groups information was not found to be posted in the licensed Residential/Assisted Living area of the facility. In an interview at that time, LPN #6 indicated she was not aware the numbers were required to be posted. In an interview on 1/16/13 at 10:00 A.M., Resident #205 indicated she had not seen any signs with the Advocacy agency information.		**not recur.** A copy of the required information for all pertinent State client advocacy groups has been posted. **IV The facility will monitor the corrective action by implementing the following measures.** The posting will be reviewed monthly for 6 months to ensure compliance. Location of the state advocacy groups will be reviewed in resident council monthly for 3 months then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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R0090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any			

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	subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation and interview, the facility failed to prominently display and post a notice of their availability in an area frequented by most residents, the results of the most recent survey conducted by Federal or State surveyors, and any plan of correction. This deficiency had the potential to affect 32 of 32 residents residing in the licensed Residential/Assisted Living area of the facility. Findings include: During the environmental tour on 1/16/13 at 8:50 A.M., with LPN #6 in attendance, a binder containing the survey report was located on a table at the entrance to the Residential/Assisted Living area. The binder was turned so that the titled was turned away from the central lounge area. There were no other notices posted related to the location or availability	R0090	**R0090 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The survey results binder was displayed in the front lobby beside the main entrance in the community. Resident #205 (should be #505) was notified of the location of the survey results. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident's residing in the facility had the potential to be affected. **III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** All new admissions and their families will be educated upon admission on how to locate the survey results. **IV The facility will monitor the corrective action by implementing the following measures.** The posting will be reviewed monthly for 6 months to ensure compliance. Location of survey results binder will be reviewed in resident council	02/15/2013

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	on the first or second floor of the Residential area. In an interview at that time, LPN #6 indicated there were no notices posted, and a resident "could ask for the information on where to find the book." She did not know how they would locate the survey book unless they asked staff. In an interview on 1/16/13 at 10:00 A.M., Resident #205 indicated she did not know where the survey book was, and had not seen any signs on its location.		monthly for 3 months then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure 4 commonly used dryers had lint traps that were free from a build-up of lint. This deficiency had the potential to affect 32 of 32 residents residing in the licensed Residential/Assisted Living area of the facility. Findings include: The environmental tour was conducted on 1/16/13 at 8:50 A.M., with LPN #6 in attendance. The common laundry rooms on the first and second floors each had two	R0148	**R0148 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The lint traps in the dryers of the common laundry rooms on the first and second floor have been cleaned. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing in the facility could have been affected. **III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** AL staff were re-educated on the cleaning of	02/15/2013

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	dryers. The lint traps for all four dryers had a heavy build-up of lint from usage. In an interview at that time, the LPN indicated the Housekeeping Department were responsible for cleaning the lint traps, and they did so at least daily. She did not know if they checked and cleaned the lint traps more than once a day.		the lint traps in the dryers of the common laundry rooms. Common laundry room lint traps will be checked daily to ensure dryers are free of lint. **IV The facility will monitor the corrective action by implementing the following measures.** Environmental Services Director or designee will complete visual observation of lint traps 5 times a week for 4 weeks, weekly for 2 months then quarterly thereafter for a total of 12 months. Results of the monthly observation will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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R0214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, record review and interview, the facility failed to re-evaluate a resident after a fall for potential risk factors and failed to re-evaluate a resident with behaviors when a change in condition occurred for 2 of 8 residents reviewed out of a census of 36 residents. (Resident #509, #538). Findings include: 1. The record for Resident #509 was reviewed on 1/16/13 at 10:00 a.m. Diagnoses included, but were not limited to, dysphagia, muscle weakness, osteoarthritis and hypertension. A progress note, dated 11/28/12 at 10:05 p.m., for Resident #509 indicated, "Res [resident] was incont [incontinent] of urine before dinner and before going to bed...CNA [Certified Nursing Assistant] assisted with PM [at night] ADL's [activities of	R0214	**R0214 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident #509 has had a fall risk assessment completed. Resident has had no further falls from bed. Resident #538 has been discharged. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents with falls or behavior changes have the potential to be affected. **III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Licensed nursing staff were re-educated on the completion of fall events. AL IDT have been educated on the requirement to complete post fall observations and update resident service plans for any resident who have a fall or new/worsening behaviors. **IV The facility will monitor the corrective action by implementing the following measures.** DON or	02/15/2013

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	daily living] r/t [related to] gait slightly unsteady." A progress note, dated 12/07/12 at 6:14 a.m., for Resident #509 indicated, "Res called for help via call pendent...found res on floor between bed and nightstand with blood to face. Nose was swollen and right eye orbit swollen bruising of blue and red to area...Neuro checks done...to ER [emergency room]...." A progress note dated 12/07/12 at 10:52 a.m. for Resident #509 indicated, "Resident returned form hospital...Resident alert and oriented. Resident has dx [diagnosis] of closed fracture of nasal bones...." A physician's note, dated 12/07/12 at 4:54 p.m., indicated Resident #509 was evaluated related to the fall. A progress note, dated 12/07/12 at 11:28 p.m., for Resident #509 indicated, "Res called for help...to get assistance for bed. Gait is weak and slightly unsteady staff needed to gave (sic) moderate assist with ambulance (sic)...Nurse help get into bed and had res slide over to middle of mattress...Side rail provided by family put in place...."		designee will audit posclinical records of residents who fall or have new/worsening behaviors weekly for 4 weeks, monthly for 2 months, then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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	A progress note, dated 12/10/12 at 7:50 p.m., for Resident #509 indicated, "...Ambulatory with RW [rolling walker]. Gait slow, but steady." A progress note, dated 12/13/12 at 10:34 p.m., for Resident #509 indicated, "...assisted res to bathroom...noting gait is slighly (sic) unsteady...encouraged res to call for help when she feel weaker. Side rail on bed...call pendent on person...." A progress note, dated 12/16/12 at 10:09 p.m., for Resident #509 indicated, "...Res requires some asstance (sic) with PM ADL's this evening and help to put up side rail." A fall event, dated 12/07/12 at 6:09 a.m., indicated that possible contributing factors were Arthritis and Osteoporosis. The intervention indicated, "...bed rail under mattress...." The most recent service plan indicated, "...Mobility...Long Term Goal Target Date: 04/30/2013 Resident will ambulate ad lib [as desires] with/without device without fall or injury for six months. Approach Start Date: 10/30/2012 Monitor resident activities tolerance...Assist if			

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	needed...Evaluation Notes: 01/10/2013...Resident calls for assistance in am (sic) to get out of bed, to bathroom and to return to bed...." On 1/16/13 at 10:40 a.m., Resident #509's bed was observed to be a twin sized bed with a box springs and a thick top mattress. A 1/2 side rail was observed in between the box springs and mattress and was not in the up position during the observation. The resident's bed was against the wall. During an interview on 1/16/13 at 10:40 a.m., Resident #509 indicated she fell out of bed. She indicated she was not trying to get up. She indicated she uses the side rail at night. She indicated she was supposed to call staff before trying to get out of bed on her own. During an interview on 1/16/13 at 2:20 p.m., information was requested from LPN #6 related to Resident #509's fall including an updated evaluation regarding risk factors and interventions for prevention related to the resident's fall with injury. During an interview on 1/16/13 at 3:22 p.m., LPN #6 indicated Resident #509's bed she fell out of was a twin			

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	bed at the same height as the resident's current bed. LPN #6 indicated the family replaced the bed after the resident's fall because it was an old bed with a wooden frame. LPN #6 indicated the resident had been instructed to call for help before getting up. During an observation with LPN #6 present on 1/16/13 at 3:45 p.m., Resident #509's bed was measured at 2 feet and 6 inches from the floor. The record for Resident #509 lacked documentation of a thorough and updated evaluation for risk factors and interventions for prevention after a fall with injury. As of exit on 1/16/13 at 4:30 p.m., no further documentation was provided. 2. The record for Resident #538 was reviewed on 1/16/13 at 11:30 a.m. Diagnoses included, but were not limited to, athlerosclerosis, hypertension and dementia. A preadmission functional assessment dated 5/9/12 for Resident #538 indicated the resident was independent with no assistance or cues for hygiene and grooming, was			

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	independent in dressing and dresses self, was independent in mobility, independent in bathing and required reminders for showers, assessed as moderate for cognition requiring cues and reminders, assessed as minimal for mood and behaviors, independent with psychosocial interactions, independent with eating and occasional incontinence. A progress note, dated 5/26/12 at 1:56 p.m., for Resident #538 indicated, "Resident checked into apartment...." A progress note, dated 6/01/12 at 2:39 p.m., for Resident #538 indicated, "Resident seeks assistance from nursing staff multiple times per shift for tasks in room...Resident is shown each time how to complete each task, but resident unable to perform per self." A progress note, dated 6/07/12 at 5:45 p.m., for Resident #538 indicated, "Res was sitting in dinning (sic) room when staff noted bloody drainage to face...Res had several nicks from shaving self to ear and cheeks on right side...Nurse suggested that staff assist him or family to get electric razor...."			

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	A progress note, dated 6/10/12 at 1:28 p.m., for Resident #538 indicated, "...Resident is still wearing the same clothing...that he had on yesterday. Stubble noted on face appearing that resident has not shaved for several days." A progress note, dated 6/11/12 at 11:25 a.m., for Resident #538 indicated, "...Fellow residents have voiced concerns regarding resident touching their plates with his eating utensils...Has been seen picking up food from a resident that has completed their meal...Staff will begin escorting resident to and from meals...." A progress note, dated 6/11/12 at 9:34 p.m., for Resident #538 indicted, "...Res also requested scissors to cut facial hair...res incont [incontinent] of urine...unaware of this...fowl (sic) odor and had to assist with peri care r/t [related to] res did not know what to do...." A progress note, dated 6/16/12 at 8:53 p.m., for Resident #538 indicated resident needed reminders to flush toilet. A progress note, dated 6/27/12 at 3:02 p.m., for Resident #538			

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	indicated resident had scabbed areas that he picked and he informed the nurse he had disinfected the area with Lysol. The nurse smelled the Lysol. The daughter and doctor were notified and the Lysol was removed from the resident's room. A progress note, dated 7/04/12 at 7:32 a.m., for Resident #538 indicated, "res has increase confusion...stool and urine in trash with several briefs in trash...." A progress note, dated 7/31/12 at 12:41 p.m., indicated Resident #538 responded to another resident, "...Well, I have not kissed you yet...." A progress note, dated 8/04/12 at 2:19 p.m., indicated Resident #538 asked a nurse "...Can I have a kiss...." A progress note, dated 8/18/12 at 1:28 p.m., indicated Resident #538's toilet was stopped up with paper towels, Band-aid wrappers and other items. A progress note, dated 10/02/12 at 10:47 p.m., indicated Resident #538 was picking at skin and staff continued to observe the resident behaviors and redirected when he			

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HAMILTON TRACE OF FISHERS LLC	11851 CUMBERLAND RD FISHERS, IN 46037

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	was seen picking his skin. Staff needed to cue the resident 3 times to change soiled brief. A progress note, dated 10/12/12 at 6:19 p.m., indicated the resident was confused and became inpatient and his tone was harsh and irritated when redirected. A progress note, dated 10/16/12 at 2:58 p.m., indicated, "...Res has been unable to do simple ADL's for last month and a half. Res has been increasingly unaware of the need to change pull up and often walks around unit with soiled pull up...." A progress note, dated 11/11/12 at 7:02 p.m., indicted Resident #538 unable to take directions from the staff. A functional assessment, dated 8/1/12 at 10:37 a.m., indicated, "...Hygiene & Grooming...Self completes tasks with occasional cues and little assistance...Bathing...Self completes task with occasional cues and assistance...Responds appropriately; requires verbal cues...Episodes involving physical;verbal/disruptive behavior;...difficult to reason with; episodes occur 1-2 times a			

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	month...Occasionally incontinent...." The most recent functional assessment, dated 11/16/12 at 2:18 p.m., indicated, "...Hygiene & Grooming...Requires cues, general assistance to complete tasks, staff monitors self-effort...Needs some assistance with dressing...Requires cues and assist with washing hard to reach areas...Responds appropriately; requires frequent verbal cues and reminders...Consistent, pleasant, reasonable and controlled moods...Continence/Toileting:...Need s cues; staff monitors proper hygiene...." During an interview, on 1/16/12 at 3:30 p.m., LPN #6 indicated she started talking to the family 60 days prior to the resident's discharge when the resident started having toilet issues, but the family did not return phone calls. LPN #6 indicated Resident #538 was never a wander risk and was easily re-directed. LPN #6 indicated the resident was appropriate "until the very end."			

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R0216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to evaluate the ability of the residents to give themselves their own medications. (Resident #550 and # 514) Findings include: 1. Record review for Resident # 505 was completed on 1/16/13 at 9:00 A.M. Resident #505 was admitted on 12/29/11. Diagnoses included, but were not limited to, hyperlipidemia, non insulin diabetes mellitus, and high blood pressure. The computer records were reviewed for Resident #505. The areas for physicians orders, documents, progress notes, observations, and events had a self medication	R0216	**R0216 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** A self-administration observation was completed on 1/11/13 for Resident #505 and #514 prior to survey being conducted on 1/16/13. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident's that self-administer medications residing in the facility had the potential to be affected. **III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Resident self-administration orders will be entered into the clinical record. License nursing staff were	02/15/2013

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	evaluation dated 1/11/13. There were no other self-medication evaluations found. A request was made to LPN #6, on 1/16/13 at 11:A.M., for any self-medication evaluations done on Resident #505 upon admission on 12/29/11. In an interview with LPN # 6 on 1/16/13 at 3:15 P.M., she indicated she could not find any other self-medication evaluation than the one dated 1/11/13 for Resident #505. 2. The clinical record for Resident #514 was reviewed on 1/16/13 at 10:10 A.M. A physician's order, on 9/10/12, indicated the resident "May keep and dispense own medications." An evaluation of the resident's ability to self-administer her own medications was not found in the electronic health record. In an interview on 1/16/13 at 2:15 P.M., LPN #6 indicated she was unable to locate any past evaluations related to the resident's ability to administer her own medications. She		re-educated on entering self-administration orders into the clinical record. **IV The facility will monitor the corrective action by implementing the following measures.** DON or designee will audit self-administration orders monthly times 3 months then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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	indicated she had recently completed re-evaluations of all residents who were able to administer their own medications. She identified the evaluation for Resident #514, and it was dated 1/11/13.			

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R0275	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on record review and interview, the facility failed to ensure diet orders were provided so they could be reviewed and updated by physician as needed. (Resident #505, Resident #531, Resident #501) Findings include: 1. Record review for Resident # 505 was completed on 1/16/13 at 9:00 A.M. Resident #505 was admitted on 12/29/11. Diagnoses included, but were not limited to, hyperlipidemia, non insulin diabetes mellitus, and high blood pressure. The computer records were reviewed for Resident #505. The areas for physicians orders, documents, progress notes, observations, and events had no diet orders. A request was made to LPN #6, on 1/16/13 at 12:00 P.M., for the diet orders from the admission of Resident #505. In an interview with LPN # 6, on 1/16/13 at 3:15 P.M., she indicated she could not find any diet orders	R0275	**R0275** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Diet order was entered in clinical record for Resident #505, #531, and #501. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident's residing in the facility have the potential to be affected.	02/15/2013

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	other than the ones dated 1/16/13 for Resident #505. 2. Record review for Resident # 531 was completed on 1/16/13 at 10:15 A.M. Diagnoses included, but were not limited to, end stage renal disease and dementia. The computer records were reviewed for Resident #531. The areas for physicians orders, documents, progress notes, observations, and events had no diet orders. A request was made to LPN #6, on 1/16/13 at 12:00 P.M., for the diet orders from the admission of Resident #531. In an interview with LPN # 6, on 1/16/13 at 3:15 P.M., she indicated she could not find any diet orders other than the ones dated 1/16/13, for Resident #531.		**III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Resident diet order will be entered into clinical record upon admission. License nursing staff were re-educated on entering diet orders on admission. **IV The facility will monitor the corrective action by implementing the following measures.** DON or designee will audit diet orders monthly times 3 months then quarterly thereafter for a total of 12 months. Results of this audit will be reviewed at the monthly	

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			Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	
	3. The clinical record for Resident #501 was reviewed on 1/16/13 at 1:35 P.M. A diet order from the physician was not found in the electronic health record. In an interview, on 1/16/13 at 3:20 P.M., LPN #6 indicated there had been a diet order on the resident's transfer form upon admission in 2011, but it had not been transcribed into his facility clinical record.			

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R0408	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review, the facility failed to obtain a diagnostic chest x-ray no more than six months prior to admission, for 1 of 9 residents reviewed. [Resident #514] Findings include: The clinical record for Resident #514 was reviewed on 1/16/13 at 10:10 A.M. The resident was admitted to the facility 5/31/12, with diagnoses that included, but were not limited to, cough, diabetes, hypertension, and chronic pain. One chest x-ray was located in the electronic health record, but was dated 8/26/11. A diagnostic chest x-ray completed within 6 months of the resident's admission to the facility was not found. In an interview, on 1/16/13 at 2:15 P.M., LPN #6 indicated she was not able to locate any other chest x-ray that would have been done within the 6 month time frame.	R0408	**R0408** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident #514 has a current chest X-Ray showing no active disease. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** New residents admitting to the AL community have the potential to be affected.	02/15/2013

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			III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. AL residents will have a diagnostic chest x-ray within 6 months of the resident's admission to the community. Licensed nursing staff and Director of Marketing have been re-educated that chest x-rays must be completed within 6 months of admission to the community. **IV The facility will monitor the corrective action by implementing the following measures.** The DON/designee will audit new AL pre-admission paperwork 1 week prior to	

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			admission for 3 months and then quarterly thereafter for a total of 12 months. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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R0410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to determine if a tuberculin skin test for infectious tuberculosis had been completed within three months prior to admission, or failed to complete a tuberculin skin test upon admission; for 2 of 9 residents reviewed. (Resident #514, Resident #538) Findings include: The clinical record for Resident #514 was reviewed on 1/16/13 at 10:10 A.M. The resident was admitted to	R0410	**R0410 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Resident #514 has a current two step TB test completed. Resident #538 has been discharged. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing in the AL community have the potential to be affected. Resident medical records were audited for most recent Tuberculin skin testing and updated as needed. **III. The facility will put into**	02/15/2013

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	the facility on 5/31/12 from home, with diagnoses that included, but were not limited to, cough, diabetes, hypertension, and chronic pain. A Nurse's Progress notes, dated 6/2/12, indicated the resident had arrived at 11:48 P.M. with her family; and a note on 6/3/12, indicated she had left early in the morning for a Leave of Absence with her family. A note on 6/4/12, indicated the resident had been in the facility all day. The electronic health record e-MAR [electronic Medication Administration Record] indicated a tuberculin skin test, although ordered upon admission, was not administered until 6/18/12. In an interview on 1/16/13 at 2:15 P.M., LPN #6 verified that the first step tuberculin test was not administered until 6/18/12. She indicated she was unable to locate documentation of any other tuberculin skin test prior to that one. 2. The record for Resident #538 was reviewed on 1/16/13 at 11:30 a.m. Diagnoses included, but were not limited to, athlerosclerosis, hypertension and dementia.		**place the following systematic changes to ensure that the deficient practice does not recur.** AL residents will have an initial Tuberculin skin test upon admission per regulation. Licensed nursing staff have been re-educated on Tuberculin skin testing guidelines. **IV The facility will monitor the corrective action by implementing the following measures.** The DON or designee will audit new AL admissions Tuberculin skin test weekly for one month, monthly for 3 months and then quarterly thereafter for a total of 12 months. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2013.	

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	A progress note, dated 5/26/12 at 1:56 p.m., for Resident #538 indicated, "Resident checked into apartment...." An Electronic Medical Record [EMAR] for Resident #538 indicated a tuberculin skin test was administered on 6/2/12, and read on 6/4/12. The record for Resident #538 lacked documentation that a tuberculin skin test was administered to Resident #538 prior to or upon admission to the facility. Documentation of an initial tuberculin skin test for Resident #538 prior to or upon admission to the facility was requested from Licensed Practical Nurse [LPN] #6 on 1/16/13 at 2:20 p.m. During an interview on 1/16/13 at 3:30 p.m., LPN #6 indicated the record for Resident #538 lacked documentation that an initial tuberculin skin test was administered prior to or upon admission to the facility.			

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